

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005099</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/05/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>COLUMBUS REGIONAL HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2400 E 17TH ST</b> <b>COLUMBUS, IN 47201</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one (1) State complaint.</p> <p>Date of survey: 09-05-13</p> <p>Facility number: 005099</p> <p>Complaint number: IN00134198</p> <p>Substantiated: No deficiencies cited.</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Columbus Regional Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services and 410 IAC 15-1.5-2, Infection control, Hospital Licensure Rules.</p> <p>QA: cloughlin 09/23/13</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE